BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: H-5132.1/04

ATTY/TYPIST: KT:ads

BRIEF DESCRIPTION:

By Representative Lantz

ESSB 5728 - H COMM AMD
By Committee on Judiciary

Strike everything after the enacting clause and insert the following:

"**PART I - MEDICAL LIABILITY**

Sec. 1. RCW 4.22.070 and 1993 c 496 s 1 are each amended to read as follows:

(1) In all actions involving fault of more than one entity, the trier of fact shall determine the percentage of the total fault which is attributable to every entity which caused the claimant's damages except entities immune from liability to the claimant under Title 51 RCW. The sum of the percentages of the total fault attributed to at-fault entities shall equal one hundred percent. The entities whose fault shall be determined include the claimant or person suffering personal injury or incurring property damage, defendants, third-party defendants, entities released by the claimant, entities with any other individual defense against the claimant, and entities immune from liability to the claimant, but shall not include those entities immune from liability to the claimant under Title 51 RCW. Judgment shall be entered against each defendant except those who have been released by the claimant or are immune from liability to the claimant or have prevailed on any other individual defense against the claimant in an amount which represents that party's proportionate share of the claimant's total damages. The liability of each defendant shall be several only and shall not be joint except:

(a) A party shall be responsible for the fault of another person or for payment of the proportionate share of another party where both were acting in concert or when a person was acting as an agent or servant of the party.

(b)(i) Except as provided in (b)(ii) of this subsection, if the trier of fact determines that the claimant or party suffering bodily

injury or incurring property damages was not at fault, the defendants against whom judgment is entered shall be jointly and severally liable for the sum of their proportionate shares of the ((~~claimants [claimant's]~~)) claimant's total damages.

(ii) Subsection (b)(i) of this subsection does not apply to health care providers as defined in RCW 7.70.020, in all cases governed by chapter 7.70 RCW with respect to judgments for noneconomic damages. In all cases governed by chapter 7.70 RCW, the liability of health care providers for noneconomic damages is several only. For the purposes of this section, "noneconomic damages" has the meaning given in RCW 4.56.250.

(2) In all actions for damages under chapter 7.70 RCW, the entities to whom fault may be attributed shall be limited to the claimants, defendants, and third-party defendants who are parties to the action any entities released by the claimant, and entities immune from liability to the claimant.

(3) If a defendant is jointly and severally liable under one of the exceptions listed in subsections (1)(a) or (1)(b) of this section, such defendant's rights to contribution against another jointly and severally liable defendant, and the effect of settlement by either such defendant, shall be determined under RCW 4.22.040, 4.22.050, and 4.22.060.

((~~(3)~~)) (4)(a) Nothing in this section affects any cause of action relating to hazardous wastes or substances or solid waste disposal sites.

(b) Nothing in this section shall affect a cause of action arising from the tortious interference with contracts or business relations.

(c) Nothing in this section shall affect any cause of action arising from the manufacture or marketing of a fungible product in a generic form which contains no clearly identifiable shape, color, or marking.

Sec. 2. RCW 70.105.112 and 1987 c 528 s 9 are each amended to read as follows:

This chapter does not apply to special incinerator ash regulated under chapter 70.138 RCW except that, for purposes of RCW

4.22.070((~~(3)~~)) (4)(a), special incinerator ash shall be considered hazardous waste.

Sec. 3. RCW 7.70.080 and 1975-'76 2nd ex.s. c 56 s 13 are each amended to read as follows:

Any party may present evidence to the trier of fact that the ((~~patient~~)) plaintiff has already been compensated for the injury complained of from any source except the assets of the ((~~patient, his~~)) plaintiff, the plaintiff's representative, or ((~~his~~)) the plaintiff's immediate family((~~, or insurance purchased with such assets~~)). In the event such evidence is admitted, the plaintiff may present evidence of an obligation to repay such compensation and evidence of any amount paid by the plaintiff, or his or her representative or immediate family, to secure the right to the compensation. ((~~Insurance bargained for or provided on behalf of an employee shall be considered insurance purchased with the assets of the employee.~~)) Compensation as used in this section shall mean payment of money or other property to or on behalf of the patient, rendering of services to the patient free of charge to the patient, or indemnification of expenses incurred by or on behalf of the patient. Notwithstanding this section, evidence of compensation by a defendant health care provider may be offered only by that provider.

NEW SECTION. **Sec. 4.** The legislature intends, by establishing a six-year statute of repose in RCW 4.16.350, to respond to the court's decision in *DeYoung v. Providence Medical Center*, 136 Wn.2d 136 (1998), by expressly stating the legislature's rationale for a statute of repose.

The legislature recognizes that a six-year statute of repose alone may not solve the crisis in the medical insurance industry. However, to the extent that a six-year statute of repose has an effect on medical malpractice insurance, that effect will tend to reduce rather than increase the cost of malpractice insurance.

Whether or not the statute of repose has the actual effect of reducing insurance costs, the legislature finds it will provide protection against claims, however few, that are stale, based on untrustworthy evidence, or that place undue burdens on defendants.

In accordance with the court's opinion in *DeYoung*, the legislature further finds that compelling even one defendant to answer a stale claim is a substantial wrong, and setting an outer limit to the operation of the discovery rule is an appropriate aim.

The legislature further finds that a six-year statute of repose is a reasonable time period in light of the need to balance the interests of injured plaintiffs and the health care industry.

The legislature intends to establish a six-year statute of repose in section 5 of this act and specifically set forth for the court the legislature's legitimate rationale for adopting the six-year statute of repose. The legislature further intends that the six-year statute of repose established in section 5 of this act be applied to actions commenced on or after the effective date of this section.

Sec. 5. RCW 4.16.350 and 1998 c 147 s 1 are each amended to read as follows:

(1) Any civil action for damages that is based upon alleged professional negligence, that is for an injury or condition occurring as a result of health care which is provided after June 25, 1976, and that is brought against((÷

~~(1)~~)) a person or entity identified in subsection (2) of this section, shall:

(a) With respect to a patient who was eighteen years old or older at the time of the act or omission alleged to have caused the injury or condition, be commenced by the later of:

(i) Three years from the act or omission; or

(ii) One year from the time the patient or his or her representative discovered or reasonably should have discovered that the injury or condition was caused by the act or omission; and

(b) With respect to a patient who was under the age of eighteen years at the time of the act or omission alleged to have caused the injury or condition, be commenced by the later of:

(i) When the patient reaches age twenty-one or six years from the act or omission, whichever occurs first; or

(ii) One year from the time the patient or his or her representative discovered or reasonably should have discovered that the injury or condition was caused by the act or omission; and

(c) Notwithstanding (a) or (b) of this subsection, in any event be commenced no later than six years after the act or omission.

(2) Persons or entities against whom an action is brought under subsection (1) of this section include:

(a) A person licensed by this state to provide health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, podiatric physician and surgeon, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his or her estate or personal representative;

((~~(2)~~)) (b) An employee or agent of a person described in (a) of this subsection ((~~(1) of this section~~)), acting in the course and scope of his or her employment, including, in the event such employee or agent is deceased, his or her estate or personal representative; or

((~~(3)~~)) (c) An entity, whether or not incorporated, facility, or institution employing one or more persons described in (a) of this subsection ((~~(1) of this section~~)), including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his or her employment, including, in the event such officer, director, employee, or agent is deceased, his or her estate or personal representative((~~;~~

~~based upon alleged professional negligence shall be commenced within three years of the act or omission alleged to have caused the injury or condition, or one year of the time the patient or his representative discovered or reasonably should have discovered that the injury or condition was caused by said act or omission, whichever period expires later, except that in no event shall an action be commenced more than eight years after said act or omission: PROVIDED, That~~)).

(3) The time for commencement of an action is tolled upon proof of fraud, intentional concealment, or the presence of a foreign body not intended to have a therapeutic or diagnostic purpose or effect, until the date the patient or the patient's representative has actual knowledge of the act of fraud or concealment, or of the presence of the

foreign body; the patient or the patient's representative has one year from the date of the actual knowledge in which to commence a civil action for damages.

(4) For purposes of this section, ((~~notwithstanding RCW 4.16.190,~~)) the knowledge of a custodial parent or guardian shall be imputed to a person under the age of eighteen years, and such imputed knowledge shall operate to bar the claim of such minor to the same extent that the claim of an adult would be barred under this section. Any action not commenced in accordance with this section shall be barred.

For purposes of this section, with respect to care provided after June 25, 1976, and before August 1, 1986, the knowledge of a custodial parent or guardian shall be imputed as of April 29, 1987, to persons under the age of eighteen years.

This section does not apply to a civil action based on intentional conduct brought against those individuals or entities specified in this section by a person for recovery of damages for injury occurring as a result of childhood sexual abuse as defined in RCW 4.16.340(5).

Sec. 6. RCW 4.16.190 and 1993 c 232 s 1 are each amended to read as follows:

(1) Unless otherwise provided in this section, if a person entitled to bring an action mentioned in this chapter, except for a penalty or forfeiture, or against a sheriff or other officer, for an escape, be at the time the cause of action accrued either under the age of eighteen years, or incompetent or disabled to such a degree that he or she cannot understand the nature of the proceedings, such incompetency or disability as determined according to chapter 11.88 RCW, or imprisoned on a criminal charge prior to sentencing, the time of such disability shall not be a part of the time limited for the commencement of action.

(2) Subsection (1) of this section with respect to a person under the age of eighteen years does not apply to the time limited for the commencement of an action under RCW 4.16.350.

Sec. 7. RCW 7.70.100 and 1993 c 492 s 419 are each amended to read as follows:

(1) No action based upon a health care provider's professional negligence may be commenced unless the defendant has been given at

least ninety days' notice of the intention to commence the action. If the notice is served within ninety days of the expiration of the applicable statute of limitations, the time for the commencement of the action must be extended ninety days from the service of the notice.

(2) The provisions of subsection (1) of this section are not applicable with respect to any defendant whose name is unknown to the plaintiff at the time of filing the complaint and who is identified therein by a fictitious name.

(3) After the filing of the ninety-day presuit notice, and before a superior court trial, all causes of action, whether based in tort, contract, or otherwise, for damages arising from injury occurring as a result of health care provided after July 1, 1993, shall be subject to mandatory mediation prior to trial except as provided in subsection (6) of this section.

((~~(2)~~)) (4) The supreme court shall by rule adopt procedures to implement mandatory mediation of actions under this chapter. The rules shall require mandatory mediation without exception unless subsection (6) of this section applies. The rules on mandatory mediation shall address, at a minimum:

(a) Procedures for the appointment of, and qualifications of, mediators. A mediator shall have experience or expertise related to actions arising from injury occurring as a result of health care, and be a member of the state bar association who has been admitted to the bar for a minimum of five years or who is a retired judge. The parties may stipulate to a nonlawyer mediator. The court may prescribe additional qualifications of mediators;

(b) Appropriate limits on the amount or manner of compensation of mediators;

(c) The number of days following the filing of a claim under this chapter within which a mediator must be selected;

(d) The method by which a mediator is selected. The rule shall provide for designation of a mediator by the superior court if the parties are unable to agree upon a mediator;

(e) The number of days following the selection of a mediator within which a mediation conference must be held; and

(f) ((~~A means by which mediation of an action under this chapter~~

~~may be waived by a mediator who has determined that the claim is not appropriate for mediation; and~~

~~(g)~~)) Any other matters deemed necessary by the court.

((~~(3)~~)) (5) Mediators shall not impose discovery schedules upon the parties.

(6) The mandatory mediation requirement of subsection (4) of this section does not apply to an action subject to mandatory arbitration under chapter 7.06 RCW or to an action in which the parties have agreed, subsequent to the arisal of the claim, to submit the claim to arbitration under chapter 7.04 RCW.

(7) The legislature respectfully requests that the supreme court by rule also adopt procedures for the parties to certify to the court the manner of mediation used by the parties to comply with this section.

NEW SECTION. **Sec. 8.** A new section is added to chapter 7.70 RCW to read as follows:

(1) In an action against a health care provider under this chapter, an expert may not provide testimony at trial, or execute a certificate of merit required under this chapter, unless the expert meets the following criteria:

(a) Has expertise in the medical condition at issue in the action; and

(b) At the time of the occurrence of the incident at issue in the action, was either:

(i) Engaged in active practice in the same or similar area of practice or specialty as the defendant; or

(ii) Teaching at an accredited medical school or an accredited or affiliated academic or clinical training program in the same or similar area of practice or specialty as the defendant, including instruction regarding the particular condition at issue.

(2) Upon motion of a party, the court may waive the requirements of subsection (1) of this section and allow an expert who does not meet those requirements to testify at trial or execute a certificate of merit required under this chapter if the court finds that:

(a) Extensive efforts were made by the party to locate an expert who meets the criteria under subsection (1) of this section, but none was willing and available to testify; and

(b) The proposed expert is qualified to be an expert witness by virtue of the person's training, experience, and knowledge.

NEW SECTION. **Sec. 9.** A new section is added to chapter 7.70 RCW to read as follows:

An expert opinion provided in the course of an action against a health care provider under this chapter must be corroborated by admissible evidence, such as, but not limited to, treatment or practice protocols or guidelines developed by medical specialty organizations, objective academic research, clinical trials or studies, or widely accepted clinical practices.

NEW SECTION. **Sec. 10.** A new section is added to chapter 7.70 RCW to read as follows:

In any action under this chapter, each side shall presumptively be entitled to only two independent experts on an issue, except upon a showing of good cause. Where there are multiple parties on a side and the parties cannot agree as to which independent experts will be called on an issue, the court, upon a showing of good cause, shall allow additional experts on an issue to be called as the court deems appropriate.

NEW SECTION. **Sec. 11.** A new section is added to chapter 7.70 RCW to read as follows:

In an action under this chapter, all parties shall submit a pretrial expert report pursuant to time frames provided in court rules. The expert report must disclose the identity of all expert witnesses and state the nature of the opinions the expert witnesses will present as testimony at trial. Further depositions of these expert witnesses is prohibited. The testimony that an expert witness may present at trial is limited in nature to the opinions disclosed to the court as part of the pretrial expert report. The legislature respectfully requests that the supreme court adopt rules to implement the provisions of this section.

NEW SECTION. **Sec. 12.** A new section is added to chapter 7.70 RCW to read as follows:

(1) In an action against an individual health care provider under this chapter for personal injury or wrongful death in which the injury is alleged to have been caused by an act or omission that violates the accepted standard of care, the plaintiff must file a certificate of merit at the time of commencing the action.

(2) The certificate of merit must be executed by a health care provider who meets the qualifications of an expert under section 8 of this act. If there is more than one defendant in the action, the person commencing the action must file a certificate of merit for each defendant.

(3) The certificate of merit must contain a statement that the person executing the certificate of merit believes, based on the information known at the time of executing the certificate of merit, that there is a reasonable probability that the defendant's conduct did not follow the accepted standard of care required to be exercised by the defendant.

(4) Upon motion of the plaintiff, the court may grant an additional period of time to file the certificate of merit, not to exceed ninety days, if the court finds there is good cause for the extension.

Sec. 13. RCW 5.64.010 and 1975-'76 2nd ex.s. c 56 s 3 are each amended to read as follows:

(1) In any civil action against a health care provider for personal injuries which is based upon alleged professional negligence ((~~and which is against:~~

~~(1) A person licensed by this state to provide health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, podiatrist, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;~~

~~(2) An employee or agent of a person described in subsection (1) of this section, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his estate or personal representative; or~~

~~(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in subsection (1) of this section, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including, in the event such officer, director, employee, or agent is deceased, his estate or personal representative;~~)), evidence of furnishing or offering or promising to pay medical, hospital, or similar expenses occasioned by an injury is not admissible to prove liability for the injury.

(2) In a civil action against a health care provider for personal injuries which is based upon alleged professional negligence, evidence of an early offer of settlement is inadmissible, not discoverable, and otherwise unavailable for use in the action. An early offer of settlement means an offer that is made before the filing of a claim and that makes an offer of compensation for the injury suffered. An early offer of settlement may include an apology or an admission of fault on the part of the person making the offer, or a statement regarding remedial actions that may be taken to address the act or omission that is the basis for the allegation of negligence, and does not become admissible, discoverable, or otherwise available for use in the action because it contains an apology, admission of fault, or statement of remedial actions that may be taken. Compensation means payment of money or other property to or on behalf of the injured party, rendering of services to the injured party free of charge, or indemnification of expenses incurred by or on behalf of the injured party.

(3) For the purposes of this section, "health care provider" has the same meaning provided in RCW 7.70.020.

NEW SECTION. **Sec. 14.** (1) A commission on noneconomic damages is established. The commission shall study the feasibility of developing and implementing an advisory schedule of noneconomic damages in actions for injuries resulting from health care under chapter 7.70 RCW. The commission shall present the results of the feasibility study and an implementation plan, if appropriate, to the relevant policy committees of the legislature by October 31, 2005.

(2) The commission's goal is to determine whether an advisory schedule could be developed to increase the predictability and proportionality of settlements and awards for noneconomic damages in actions for injuries resulting from health care and, if so, what steps are necessary to implement such a schedule. In making its determination, the commission shall consider:

(a) The information that can most appropriately be used to provide guidance to the trier of fact regarding noneconomic damage awards, giving consideration to: (i) Past noneconomic damage awards for similar injuries, considering severity and duration of the injuries; (ii) past noneconomic damage awards for similar claims for damages; and (iii) such other information or methodologies the commission finds appropriate;

(b) The most appropriate format in which to present the information to the trier of fact; and

(c) When and under what circumstances an advisory schedule should be utilized in alternative dispute resolution settings and presented to the trier of fact at trial.

(3) If the commission determines that an advisory schedule for noneconomic damages is feasible, the commission shall develop an implementation plan for the schedule which shall include, at a minimum:

(a) Identification of changes to statutory law, administrative rules, or court rules that would be necessary to implement the advisory schedule;

(b) Identification of forms or other documents that would be necessary or beneficial in implementing the advisory schedule;

(c) A proposed timetable for implementation of the advisory schedule; and

(d) Any other information or considerations the commission finds necessary or beneficial to implementation of the advisory schedule.

(4) For the purposes of this section, "noneconomic damages" has the meaning given in RCW 4.56.250.

NEW SECTION. **Sec. 15.** (1) The commission is composed of fifteen members, as follows: (a) One member from each of the two largest caucuses in the senate, to be appointed by the president of the senate, and one member from each of the two largest caucuses in the house of

representatives, to be appointed by the speaker of the house of representatives; (b) one health care ethicist; (c) one economist; (d) one actuary; (e) two attorneys, one representing the plaintiff's bar and one representing the insurance defense bar; (f) two superior court judges; (g) one representative of a hospital; (h) two physicians; and (i) one representative of a medical malpractice insurer. The governor shall appoint the nonlegislative members of the commission.

(2) The governor shall select a chair of the commission from among those commission members that are not health care providers, medical malpractice insurers, or attorneys.

(3) Legislative members of the commission shall be reimbursed for travel expenses under RCW 44.04.120. Nonlegislative members of the commission shall be reimbursed for travel expenses as provided in RCW 43.03.050 and 43.03.060. Travel expenses of nonlegislative members of the commission shall be paid jointly by the house of representatives and senate.

(4) The office of financial management shall provide support to the commission to enable it to perform its functions, with the assistance of staff from the administrative office of the courts.

NEW SECTION. **Sec. 16.** (1) The legislature finds that there has been significant controversy regarding the most appropriate means to resolve disputes related to injuries occurring as a result of health care, and that an impartial examination of all of the issues surrounding resolution of these disputes is needed. An impartial examination is an important component of efforts to address concerns raised regarding the handling and outcome of disputes related to injuries occurring as a result of health care in the current civil liability system.

(2) Through the establishment of a joint task force in section 17 of this act, the legislature intends to provide for an impartial examination of issues surrounding resolution of disputes related to injuries occurring as a result of health care, with the goal of developing recommendations for prompt resolution of these disputes that provides equitable results for all of the individuals and entities involved.

NEW SECTION. **Sec. 17.** (1) A joint task force is created to study judicial and administrative alternatives for resolving disputes related to injuries occurring as a result of health care. The task force is organized and chaired by the office of the attorney general. In addition to the office of the attorney general, members of the task force shall include:

(a) Representatives of the legislature, including one member appointed by each caucus;

(b) Representatives of the superior courts of Washington state appointed by the president of the superior court judges association, and shall include one judicial officer of the superior court from eastern Washington and one judicial officer of the superior court from western Washington;

(c) A representative of the Washington state court of appeals appointed by the chief justice of the state supreme court;

(d) A retired judge who is actively involved in mediation or arbitration of medical malpractice disputes;

(e) The secretary of the department of health;

(f) Two physician representatives of the Washington state medical association, appointed by that organization, one of whom has a medical practice and one of whom has a surgical practice. At least one of the physician representatives must practice in a specialty that is considered a high risk specialty for purposes of the availability and cost of medical malpractice insurance coverage;

(g) A representative of the Washington state hospital association, appointed by that organization;

(h) A representative of the Washington state bar association, appointed by that organization;

(i) A representative of health care consumers, appointed by the attorney general.

(2) The task force shall seek input from, and consult with, other interested health professions and organizations in the course of its deliberations.

(3) The objectives of the task force are to:

(a) Examine approaches used in other states and jurisdictions to address resolution of disputes related to injuries occurring as a result of health care, including but not limited to mediation and

arbitration, administrative compensation systems, the use of impartial medical experts chosen by the court or agreed upon by the parties, and the use of specialized courts or judges;

(b) Recommend one or more methods to resolve disputes related to injuries occurring as a result of health care, including, but not limited to, an administrative resolution process; a judicial resolution process such as medical courts, or modifications of court rules that will increase the medical knowledge of superior court judges; or any combination thereof;

(c) Recommend an implementation plan that will address:

(i) A specific administrative structure for each method used to resolve disputes related to injuries occurring as a result of health care;

(ii) The cost to implement the plan; and

(iii) The changes to statutes and court rules necessary to implement the plan.

(3) The office of the attorney general shall use staff of the office of program research and senate committee services to research and compile information relevant to the mission of the task force by December 31, 2004, and to provide other staff support services needed by the task force.

(4) The task force shall submit its report to the governor and appropriate committees of the legislature no later than November 1, 2005.

NEW SECTION. **Sec. 18.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Claim" means a demand for payment of a loss caused by medical malpractice.

(a) Two or more claims arising out of a single injury or incident of medical malpractice is one claim.

(b) A series of related incidents of medical malpractice is one claim.

(2) "Claimant" means a person filing a claim against a health care provider or health care facility.

(3) "Commissioner" means the insurance commissioner.

(4) "Health care facility" or "facility" means a clinic, diagnostic center, hospital, laboratory, mental health center, nursing home, office, surgical facility, treatment facility, or similar place where a health care provider provides health care to patients.

(5) "Health care provider" or "provider" means a health care provider as defined in RCW 48.43.005.

(6) "Insuring entity" means:

(a) An insurer;

(b) A joint underwriting association;

(c) A risk retention group; or

(d) An unauthorized insurer that provides surplus lines coverage.

(7) "Medical malpractice" means a negligent act, error, or omission in providing or failing to provide professional health care services, failure to obtain informed consent, or breach of promise of a particular result.

NEW SECTION. **Sec. 19.** (1) Beginning on April 1, 2005, every insuring entity or self-insurer that provides medical malpractice insurance to any facility or provider in Washington state must report to the commissioner by the first of each quarter any claim related to medical malpractice, if the claim resulted in a final:

(a) Judgment in any amount;

(b) Settlement in any amount; or

(c) Disposition of a medical malpractice claim resulting in no indemnity payment on behalf of an insured.

(2) If a claim is not reported by an insuring entity or self-insurer under subsection (1) of this section due to limitations in the medical malpractice coverage of a facility or provider, the facility or provider must report the claim to the commissioner.

(3) Reports under this section must be filed with the commissioner within sixty days after the claim is resolved.

(4)(a) The commissioner may impose a fine of up to two hundred fifty dollars per day per case against any insuring entity or surplus lines producer that violates the requirements of this section. The total fine per case may not exceed ten thousand dollars.

(b) The department of health may impose a fine of up to two hundred

fifty dollars per day per case against any facility or provider that violates the requirements of this section. The total fine per case may not exceed ten thousand dollars.

NEW SECTION. **Sec. 20.** The reports required under section 19 of this act must contain the following data in a form prescribed by the commissioner for each claim:

(1) The health care provider's name, address, provider professional license number, and type of medical specialty for which the provider is insured; the name of the facility, if any, and the location within the facility where the injury occurred; and the names and professional license numbers if applicable, of all defendants involved in the claim. This information is confidential and exempt from public disclosure, but may be disclosed:

(a) Publicly, if the provider or facility provides written consent; or

(b) To the commissioner at any time for the purpose of identifying multiple or duplicate claims arising out of the same occurrence;

(2) The provider or facility policy number or numbers;

(3) The date of the loss;

(4) The date the claim was reported to the insuring entity, self-insurer, facility, or provider;

(5) The name and address of the claimant. This information is confidential and exempt from public disclosure, but may be disclosed:

(a) Publicly, if the claimant provides written consent; or

(b) To the commissioner at any time for the purpose of identifying multiple or duplicate claims arising out of the same occurrence;

(6) The date of suit, if filed;

(7) The claimant's age and sex;

(8) Specific information about the judgment or settlement including:

(a) The date and amount of any judgment or settlement;

(b) Whether the settlement:

(i) Was the result of an arbitration, judgment, or mediation; and

(ii) Occurred before or after trial;

(c) An itemization of:

(i) Economic damages, such as incurred and anticipated medical expense and lost wages;

(ii) Noneconomic damages;

(iii) Allocated loss adjustment expense, including but not limited to court costs, attorneys' fees, and costs of expert witnesses; and

(d) If there is no judgment or settlement:

(i) The date and reason for final disposition; and

(ii) The date the claim was closed;

(9) A summary of the occurrence that created the claim, which must include:

(a) The final diagnosis for which the patient sought or received treatment;

(b) A description of any misdiagnosis made by the provider of the actual condition of the patient;

(c) The operation, diagnostic, or treatment procedure that caused the injury;

(d) A description of the principal injury that led to the claim; and

(e) The safety management actions the facility or provider has taken to make similar occurrences or injuries less likely in the future. This reporting requirement does not create a legal duty on the part of a facility or provider to implement safety management actions; and

(10) Any other information required by the commissioner, by rule, that helps the commissioner analyze and evaluate the nature, causes, location, cost, and damages involved in medical malpractice cases.

NEW SECTION. **Sec. 21.** The commissioner must prepare aggregate statistical summaries of closed claims based on calendar year data submitted under section 19 of this act.

(1) At a minimum, data must be sorted by calendar year and calendar accident year. The commissioner may also decide to display data in other ways.

(2) The summaries must be available by March 31st of each year.

NEW SECTION. **Sec. 22.** Beginning in 2006, the commissioner must prepare an annual report by June 30th that summarizes and analyzes the

closed claim reports for medical malpractice filed under section 19 of this act and the annual financial reports filed by insurers writing medical malpractice insurance in this state. The report must include:

(1) An analysis of closed claim reports of prior years for which data are collected and show:

(a) Trends in the frequency and severity of claims payments;

(b) An itemization of economic and noneconomic damages;

(c) The types of medical malpractice for which claims have been paid; and

(d) Any other information the commissioner determines illustrates trends in closed claims;

(2) An analysis of the medical malpractice insurance market in Washington state, including:

(a) An analysis of the financial reports of the insurers with a combined market share of at least ninety percent of net written medical malpractice premium in Washington state for the prior calendar year;

(b) A loss ratio analysis of medical malpractice insurance written in Washington state; and

(c) A profitability analysis of each insurer writing medical malpractice insurance;

(3) A comparison of loss ratios and the profitability of medical malpractice insurance in Washington state to other states based on financial reports filed with the national association of insurance commissioners and any other source of information the commissioner deems relevant;

(4) A summary of the rate filings for medical malpractice that have been approved by the commissioner for the prior calendar year, including an analysis of the trend of direct and incurred losses as compared to prior years;

(5) The commissioner must post reports required by this section on the internet no later than thirty days after they are due; and

(6) The commissioner may adopt rules that require insuring entities and self-insurers required to report under section 19(1) of this act to report data related to:

(a) The frequency and severity of open claims for the reporting period;

(b) The aggregate amounts reserved for incurred claims;

(c) Changes in reserves from the previous reporting period; and

(d) Any other information that helps the commissioner monitor losses and claims development in the Washington state medical malpractice insurance market.

NEW SECTION. **Sec. 23.** The commissioner shall adopt all rules needed to implement this chapter. To ensure that claimants and health care providers cannot be individually identified when data is disclosed to the public, the commissioner shall adopt rules that require the protection of information that, in combination, could result in the ability to identify the claimant or health care provider in a particular claim.

NEW SECTION. **Sec. 24.** A new section is added to chapter 7.70 RCW to read as follows:

(1) In any action filed under this chapter that results in a final:

(a) Judgment in any amount;

(b) Settlement in any amount; or

(c) Disposition resulting in no indemnity payment,

the claimant or his or her attorney shall report to the office of the insurance commissioner on forms provided by the commissioner any court costs, attorneys' fees, or costs of expert witnesses incurred in pursuing the action.

(2) The commissioner may adopt rules requiring the submission of any other information that would help the commissioner analyze and evaluate the costs involved in medical malpractice cases.

NEW SECTION. **Sec. 25.** A new section is added to chapter 7.70 RCW to read as follows:

(1) In an action for damages for injury occurring as a result of health care in which a verdict or award for future economic damages of at least one hundred thousand dollars is made, the court or arbitrator shall, at the request of a party, and upon agreement of any other party affected by the request, enter a judgment which provides for the periodic payment in whole or in part of the future economic damages. With respect to the judgment, the court or arbitrator shall make a

specific finding as to the dollar amount of periodic payments intended to compensate the judgment creditor for the future economic damages.

(2) Prior to entry of judgment, the court shall request each party to submit a proposal for periodic payment of future economic damages to compensate the claimant. Proposals shall include provisions for: The name of the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, the number of payments or the period of time over which the payments shall be made, modification for hardship or unforeseen circumstances, posting of adequate security, and any other factor the court deems relevant under the circumstances. After each party has submitted a proposal, the court shall select the proposal, with any changes the court deems proper, which in the discretion of the court and the interests of justice best provides for the future needs of the claimant and enter judgment accordingly.

(3) If the court enters a judgment for periodic payments and any security required by the judgment is not posted within thirty days, the court shall enter a judgment for the payment of future damages in a lump sum.

(4) If at any time following entry of judgment for periodic payments, a judgment debtor fails for any reason to make a payment in a timely fashion according to the terms of the judgment, the judgment creditor may petition the court for an order requiring payment by the judgment debtor of the outstanding payments in a lump sum. In calculating the amount of the lump sum judgment, the court shall total the remaining periodic payments due and owing to the judgment creditor converted to present value. The court may also require payment of interest on the outstanding judgment.

(5) Upon the death of the judgment creditor, the court which rendered the original judgment may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages. Money damages awarded shall not be reduced or payments terminated by reason of the death of the judgment creditor.

(6) Upon satisfaction of a periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security posted pursuant to this section shall revert to the judgment debtor.

PART II - FRIVOLOUS LAWSUITS

Sec. 26. RCW 4.84.185 and 1991 c 70 s 1 are each amended to read as follows:

In any civil action, the court having jurisdiction ((~~may~~)) shall, upon written findings by the judge that the action, counterclaim, cross-claim, third party claim, or defense was frivolous and advanced without reasonable cause, require the nonprevailing party to pay the prevailing party the reasonable expenses, including fees of attorneys and expert witnesses, incurred in opposing such action, counterclaim, cross-claim, third party claim, or defense. This determination shall be made upon motion by the prevailing party after a voluntary or involuntary order of dismissal, order on summary judgment, final judgment after trial, or other final order terminating the action as to the prevailing party. The judge shall consider all evidence presented at the time of the motion to determine whether the position of the nonprevailing party was frivolous and advanced without reasonable cause. In no event may such motion be filed more than thirty days after entry of the order.

The provisions of this section apply unless otherwise specifically provided by statute.

PART III - PATIENT SAFETY

NEW SECTION. **Sec. 27.** (1) The legislature finds that:

(a) Thousands of patients are injured each year in the United States as a result of medical errors, and that a comprehensive approach is needed to effectively reduce the incidence of medical errors in our health care system. Implementation of proven patient safety strategies can reduce medical errors, and thereby potentially reduce the need for disciplinary actions against licensed health care professionals and facilities, and the frequency and severity of medical malpractice claims; and

(b) Health care providers, health care facilities, and health carriers can and should be supported in their efforts to improve patient safety and reduce medical errors by authorizing the sharing of successful quality improvement efforts, encouraging health care

facilities and providers to communicate openly with patients regarding medical errors that have occurred and steps that can be taken to prevent errors from occurring in the future, encouraging health care facilities and providers to work cooperatively in their patient safety efforts, and increasing funding available to implement proven patient safety strategies.

(2) Through the adoption of sections 28 through 38 of this act, the legislature intends to positively influence the safety and quality of care provided in Washington state's health care system.

Sec. 28. RCW 4.24.250 and 1981 c 181 s 1 are each amended to read as follows:

(1) Any health care provider as defined in RCW 7.70.020 (1) and (2) as now existing or hereafter amended who, in good faith, files charges or presents evidence against another member of their profession based on the claimed incompetency or gross misconduct of such person before a regularly constituted review committee or board of a professional society or hospital whose duty it is to evaluate the competency and qualifications of members of the profession, including limiting the extent of practice of such person in a hospital or similar institution, or before a regularly constituted committee or board of a hospital whose duty it is to review and evaluate the quality of patient care, shall be immune from civil action for damages arising out of such activities. The proceedings, reports, and written records of such committees or boards, or of a member, employee, staff person, or investigator of such a committee or board, shall not be subject to subpoena or discovery proceedings in any civil action, except actions arising out of the recommendations of such committees or boards involving the restriction or revocation of the clinical or staff privileges of a health care provider as defined above.

(2) A coordinated quality improvement program maintained in accordance with RCW 43.70.510 or 70.41.200 may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by a coordinated quality improvement committee or committees or boards under subsection (1) of this section, with one or more other coordinated quality improvement programs for the improvement of the quality of health care services

rendered to patients and the identification and prevention of medical malpractice. The privacy protections of chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996 and its implementing regulations apply to the sharing of individually identifiable patient information held by a coordinated quality improvement program. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program and any information and documents created or maintained as a result of the sharing of information and documents shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (1) of this section and by RCW 43.70.510(4) and 70.41.200(3).

Sec. 29. RCW 43.70.510 and 1995 c 267 s 7 are each amended to read as follows:

(1)(a) Health care institutions and medical facilities, other than hospitals, that are licensed by the department, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers approved pursuant to chapter 48.43 RCW, and any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof may maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice as set forth in RCW 70.41.200.

(b) All such programs shall comply with the requirements of RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the institution, facility, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers, or any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof, unless an alternative quality improvement program substantially equivalent to RCW 70.41.200(1)(a) is developed. All such programs, whether complying with the requirement set forth in RCW 70.41.200(1)(a) or in the form of an alternative program, must be approved by the department before the discovery

limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.17.310(1)(hh) and subsection (5) of this section shall apply. In reviewing plans submitted by licensed entities that are associated with physicians' offices, the department shall ensure that the exemption under RCW 42.17.310(1)(hh) and the discovery limitations of this section are applied only to information and documents related specifically to quality improvement activities undertaken by the licensed entity.

(2) Health care provider groups of ((~~ten~~)) five or more providers may maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice as set forth in RCW 70.41.200. All such programs shall comply with the requirements of RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the health care provider group. All such programs must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.17.310(1)(hh) and subsection (5) of this section shall apply.

(3) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity. Any person or entity participating in a coordinated quality improvement program that shares information or documents with one or more other programs in good faith and in accordance with applicable confidentiality and disclosure requirements of the coordinated quality improvement committee is not subject to an action for civil damages or other relief arising out of the act of sharing them.

(4) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained by a quality improvement committee are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to

testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts that form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality improvement committees regarding such health care provider; (d) in any civil action challenging the termination of a contract by a state agency with any entity maintaining a coordinated quality improvement program under this section if the termination was on the basis of quality of care concerns, introduction into evidence of information created, collected, or maintained by the quality improvement committees of the subject entity, which may be under terms of a protective order as specified by the court; (e) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or (f) in any civil action, discovery and introduction into evidence of the patient's medical records required by rule of the department of health to be made regarding the care and treatment received.

(5) Information and documents created specifically for, and collected and maintained by a quality improvement committee are exempt from disclosure under chapter 42.17 RCW.

(6) A coordinated quality improvement program may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by a quality improvement committee or a peer review committee under RCW 4.24.250 with one or more other coordinated quality improvement programs maintained in accordance with this section or with RCW 70.41.200, for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The privacy

protections of chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996 and its implementing regulations apply to the sharing of individually identifiable patient information held by a coordinated quality improvement program. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program and any information and documents created or maintained as a result of the sharing of information and documents shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (4) of this section and RCW 4.24.250.

(7) The department of health shall adopt rules as are necessary to implement this section.

Sec. 30. RCW 70.41.200 and 2000 c 6 s 3 are each amended to read as follows:

(1) Every hospital shall maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The program shall include at least the following:

(a) The establishment of a quality improvement committee with the responsibility to review the services rendered in the hospital, both retrospectively and prospectively, in order to improve the quality of medical care of patients and to prevent medical malpractice. The committee shall oversee and coordinate the quality improvement and medical malpractice prevention program and shall ensure that information gathered pursuant to the program is used to review and to revise hospital policies and procedures;

(b) A medical staff privileges sanction procedure through which credentials, physical and mental capacity, and competence in delivering health care services are periodically reviewed as part of an evaluation of staff privileges;

(c) The periodic review of the credentials, physical and mental capacity, and competence in delivering health care services of all persons who are employed or associated with the hospital;

(d) A procedure for the prompt resolution of grievances by patients or their representatives related to accidents, injuries, treatment, and other events that may result in claims of medical malpractice;

(e) The maintenance and continuous collection of information concerning the hospital's experience with negative health care outcomes and incidents injurious to patients, patient grievances, professional liability premiums, settlements, awards, costs incurred by the hospital for patient injury prevention, and safety improvement activities;

(f) The maintenance of relevant and appropriate information gathered pursuant to (a) through (e) of this subsection concerning individual physicians within the physician's personnel or credential file maintained by the hospital;

(g) Education programs dealing with quality improvement, patient safety, medication errors, injury prevention, staff responsibility to report professional misconduct, the legal aspects of patient care, improved communication with patients, and causes of malpractice claims for staff personnel engaged in patient care activities; and

(h) Policies to ensure compliance with the reporting requirements of this section.

(2) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity. Any person or entity participating in a coordinated quality improvement program that shares information or documents with one or more other programs in good faith and in accordance with applicable confidentiality and disclosure requirements of the coordinated quality improvement committee is not subject to an action for civil damages or other relief arising out of the act of sharing them.

(3) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained by a quality improvement committee are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the

discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts which form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality improvement committees regarding such health care provider; (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by regulation of the department of health to be made regarding the care and treatment received.

(4) Each quality improvement committee shall, on at least a semiannual basis, report to the governing board of the hospital in which the committee is located. The report shall review the quality improvement activities conducted by the committee, and any actions taken as a result of those activities.

(5) The department of health shall adopt such rules as are deemed appropriate to effectuate the purposes of this section.

(6) The medical quality assurance commission or the board of osteopathic medicine and surgery, as appropriate, may review and audit the records of committee decisions in which a physician's privileges are terminated or restricted. Each hospital shall produce and make accessible to the commission or board the appropriate records and otherwise facilitate the review and audit. Information so gained shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (3) of this section. Failure of a hospital to comply with this subsection is punishable by a civil penalty not to exceed two hundred fifty dollars.

(7) The department, the joint commission on accreditation of health care organizations, and any other accrediting organization may review and audit the records of a quality improvement committee or peer review committee in connection with their inspection and review of hospitals.

Information so obtained shall not be subject to the discovery process, and confidentiality shall be respected as required by subsection (3) of this section. Each hospital shall produce and make accessible to the department the appropriate records and otherwise facilitate the review and audit.

(8) A coordinated quality improvement program may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by a quality improvement committee or a peer review committee under RCW 4.24.250 with one or more other coordinated quality improvement programs maintained in accordance with this section or with RCW 43.70.510, for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The privacy protections of chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996 and its implementing regulations apply to the sharing of individually identifiable patient information held by a coordinated quality improvement program. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program and any information and documents created or maintained as a result of the sharing of information and documents shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (3) of this section and RCW 4.24.250.

(9) Violation of this section shall not be considered negligence per se.

Sec. 31. RCW 43.70.110 and 1993 sp.s. c 24 s 918 are each amended to read as follows:

(1) The secretary shall charge fees to the licensee for obtaining a license. After June 30, 1995, municipal corporations providing emergency medical care and transportation services pursuant to chapter 18.73 RCW shall be exempt from such fees, provided that such other emergency services shall only be charged for their pro rata share of the cost of licensure and inspection, if appropriate. The secretary may waive the fees when, in the discretion of the secretary, the fees would not be in the best interest of public health and safety, or when the fees would be to the financial disadvantage of the state.

(2) Except as provided in section 33 of this act, fees charged shall be based on, but shall not exceed, the cost to the department for the licensure of the activity or class of activities and may include costs of necessary inspection.

(3) Department of health advisory committees may review fees established by the secretary for licenses and comment upon the appropriateness of the level of such fees.

Sec. 32. RCW 43.70.250 and 1996 c 191 s 1 are each amended to read as follows:

It shall be the policy of the state of Washington that the cost of each professional, occupational, or business licensing program be fully borne by the members of that profession, occupation, or business. The secretary shall from time to time establish the amount of all application fees, license fees, registration fees, examination fees, permit fees, renewal fees, and any other fee associated with licensing or regulation of professions, occupations, or businesses administered by the department. In fixing said fees, the secretary shall set the fees for each program at a sufficient level to defray the costs of administering that program and the patient safety fee established in section 33 of this act. All such fees shall be fixed by rule adopted by the secretary in accordance with the provisions of the administrative procedure act, chapter 34.05 RCW.

NEW SECTION. **Sec. 33.** A new section is added to chapter 43.70 RCW to read as follows:

(1) The secretary shall increase the licensing fee established under RCW 43.70.110 by two dollars per year for the health care professionals designated in subsection (2) of this section and by two dollars per licensed bed per year for the health care facilities designated in subsection (2) of this section. Proceeds of the patient safety fee must be deposited into the patient safety account in section 37 of this act and dedicated to patient safety and medical error reduction efforts that have been proven to improve, or have a substantial likelihood of improving the quality of care provided by health care professionals and facilities.

(2) The health care professionals and facilities subject to the patient safety fee are:

(a) The following health care professionals licensed under Title 18 RCW:

(i) Advanced registered nurse practitioners, registered nurses, and licensed practical nurses licensed under chapter 18.79 RCW;

(ii) Chiropractors licensed under chapter 18.25 RCW;

(iii) Dentists licensed under chapter 18.32 RCW;

(iv) Midwives licensed under chapter 18.50 RCW;

(v) Naturopaths licensed under chapter 18.36A RCW;

(vi) Nursing home administrators licensed under chapter 18.52 RCW;

(vii) Optometrists licensed under chapter 18.53 RCW;

(viii) Osteopathic physicians licensed under chapter 18.57 RCW;

(ix) Osteopathic physicians' assistants licensed under chapter 18.57A RCW;

(x) Pharmacists and pharmacies licensed under chapter 18.64 RCW;

(xi) Physicians licensed under chapter 18.71 RCW;

(xii) Physician assistants licensed under chapter 18.71A RCW;

(xiii) Podiatrists licensed under chapter 18.22 RCW; and

(xiv) Psychologists licensed under chapter 18.83 RCW; and

(b) Hospitals licensed under chapter 70.41 RCW and psychiatric hospitals licensed under chapter 71.12 RCW.

NEW SECTION. **Sec. 34.** A new section is added to chapter 7.70 RCW to read as follows:

(1)(a) One percent of any attorney contingency fee as contracted with a prevailing plaintiff in any action for damages based upon injuries resulting from health care shall be deducted from the contingency fee as a patient safety set aside. Proceeds of the patient safety set aside will be distributed by the department of health in the form of grants, loans, or other appropriate arrangements to support strategies that have been proven to reduce medical errors and enhance patient safety, or have a substantial likelihood of reducing medical errors and enhancing patient safety, as provided in section 33 of this act.

(b) A patient safety set aside shall be transmitted to the

secretary of the department of health by the person or entity paying the claim, settlement, or verdict for deposit into the patient safety account established in section 37 of this act.

(c) The supreme court shall by rule adopt procedures to implement this section.

(2) If the patient safety set aside established by this section is invalidated by the Washington state supreme court, then any attorney representing a claimant who receives a settlement or verdict in any action for damages based upon injuries resulting from health care under this chapter shall provide information to the claimant regarding the existence and purpose of the patient safety account and notify the claimant that he or she may make a contribution to that account under section 36 of this act.

NEW SECTION. **Sec. 35.** A new section is added to chapter 43.70 RCW to read as follows:

(1)(a) Patient safety fee and set aside proceeds shall be administered by the department, after seeking input from health care providers engaged in direct patient care activities, health care facilities, and other interested parties. In developing criteria for the award of grants, loans, or other appropriate arrangements under this section, the department shall rely primarily upon evidence-based practices to improve patient safety that have been identified and recommended by governmental and private organizations, including, but not limited to:

(i) The federal agency for health care quality and research;

(ii) The institute of medicine of the national academy of sciences;

(iii) The joint commission on accreditation of health care organizations; and

(iv) The national quality forum.

(b) The department shall award grants, loans, or other appropriate arrangements for at least two strategies that are designed to meet the goals and recommendations of the federal institute of medicine's report, "Keeping Patients Safe: Transforming the Work Environment of Nurses."

(2) Projects that have been proven to reduce medical errors and enhance patient safety shall receive priority for funding over those

that are not proven, but have a substantial likelihood of reducing medical errors and enhancing patient safety. All project proposals must include specific performance and outcome measures by which to evaluate the effectiveness of the project. Project proposals that do not propose to use a proven patient safety strategy must include, in addition to performance and outcome measures, a detailed description of the anticipated outcomes of the project based upon any available related research and the steps for achieving those outcomes.

(3) The department may use a portion of the patient safety fee proceeds for the costs of administering the program.

NEW SECTION. **Sec. 36.** A new section is added to chapter 43.70 RCW to read as follows:

The secretary may solicit and accept grants or other funds from public and private sources to support patient safety and medical error reduction efforts under sections 31 through 38 of this act. Any grants or funds received may be used to enhance these activities as long as program standards established by the secretary are followed.

NEW SECTION. **Sec. 37.** A new section is added to chapter 43.70 RCW to read as follows:

The patient safety account is created in the state treasury. All receipts from the fees and set asides created in sections 33 and 34 of this act must be deposited into the account. Expenditures from the account may be used only for the purposes of sections 31 through 38 of this act. Moneys in the account may be spent only after appropriation.

NEW SECTION. **Sec. 38.** A new section is added to chapter 43.70 RCW to read as follows:

By December 1, 2007, the department shall report the following information to the governor and the health policy and fiscal committees of the legislature:

(1) The amount of patient safety fees and set asides deposited to date in the patient safety account;

(2) The criteria for distribution of grants, loans, or other appropriate arrangements under sections 31 through 38 of this act; and

(3) A description of the medical error reduction and patient safety grants and loans distributed to date, including the stated performance measures, activities, timelines, and detailed information regarding outcomes for each project.

PART IV - HEALTH PROFESSIONS DISCIPLINE

NEW SECTION. **Sec. 39.** The legislature finds that:

(1) The protection of the health and safety of the people of Washington state is a paramount responsibility entrusted to the state. One of the means for achieving such protection is through regulation of health professionals and effective discipline of those health care professionals who engage in unprofessional conduct. The vast majority of health professionals are dedicated to their profession, and provide quality services to those in their care. However, effective mechanisms are needed to ensure that the small minority of health professionals who engage in unprofessional conduct are reported and disciplined in a timely and effective manner.

(2) Jurisdiction for health professions disciplinary processes is divided between the secretary of health and fourteen independent boards and commissions. While the presence of a board or commission consisting of members of the profession that they regulate may add value to some steps of the disciplinary process, in other instances their involvement may be unnecessary, or even an impediment, to safeguarding the public's health and safety. It is in the interests of both public health and safety and credentialed health care professionals that the health professions disciplinary system operate effectively and appropriately.

NEW SECTION. **Sec. 40.** (1) The task force on improvement of health professions discipline is established. The governor must appoint its members, and shall include:

(a) A representative of a medicare contracted professional review organization in Washington state;

(b) One or more representatives of the University of Washington school of health sciences or school of public health with expertise in health professions regulation;

(c) A representative of the foundation for health care quality;

(d) Four representatives of a broad range of different types of health care professionals, including one physician, none of whom currently serve, or have served in the past, on a health professions disciplinary board or commission;

(e) A representative of hospital-based continuous quality improvement programs under RCW 70.41.200;

(f) A representative of a hospital peer review committee;

(g) The secretary of the department of health;

(h) A representative of the superior court judges association;

(i) A representative of the Washington state bar association who is an attorney with expertise in defending health professionals in health professions disciplinary proceedings in Washington;

(j) A representative of health care consumers, who does not currently serve and has not in the past served, on a health professions disciplinary board or commission;

(k) The attorney general or his or her designee; and

(l) Three members of the public, one of whom is a current or former public member of a disciplining authority included in chapter 18.130 RCW.

(2) The task force shall conduct an independent review of the funding of the health professions and all phases of the current health professions disciplinary process, from report intake through final case closure, and shall, at a minimum, examine and address the following issues:

(a) The ability of the disciplining authorities identified in RCW 18.130.040 to effectively safeguard the public from potentially harmful health care practitioners while also ensuring the due process rights of credentialed health care practitioners;

(b) The feasibility of developing a uniform performance measurement system for health professions discipline;

(c) Whether there are components to the current health professions discipline system that serve as impediments to improving the quality of health professions discipline, including consideration of:

(i) The value of boards and commissions in the health professions disciplinary process; and

(ii) The respective roles of the secretary and boards and commissions in health professions disciplinary functions;

(d) The feasibility of allowing law enforcement agencies to share information from criminal investigations of credentialed health care providers regardless of whether the provider was not ultimately convicted;

(e) The extent to which investigation, charging, and sanctioning decisions are consistently applied across and within each of the disciplining authorities;

(f) The merits of limiting the public disclosure of certain information related to the health professions disciplinary process including complaint closure without investigation, complaint closure after investigation, and findings after adjudication of no violation of the uniform disciplinary act;

(g) The extent to which sanctions deviate from advisory guidelines regarding sanctions and the circumstances behind those deviations; and

(h) Alternative fee structures for health care professionals to simplify funding and the use of those funds across all health care professions.

(3) The task force may establish technical advisory committees to assist in its efforts, and shall provide opportunities for interested parties to comment upon the task force's findings and recommendations prior to being finalized.

(4) Staff support to the task force shall be provided by the department of health and the office of financial management.

(5) The task force shall submit its report and recommendations for improvement of health professions discipline to the relevant committees of the legislature and the governor by October 1, 2005.

(6) Nothing in sections 39 through 45 of this act limits the secretary of health's authority to modify the internal processes or organizational framework of the department.

(7) Members of the task force shall be reimbursed for travel expenses as provided in RCW 43.03.050 and 43.03.060.

Sec. 41. RCW 4.24.260 and 1994 sp.s. c 9 s 701 are each amended to read as follows:

((~~Physicians licensed under chapter 18.71 RCW, dentists licensed~~

~~under chapter 18.32 RCW, and pharmacists licensed under chapter 18.64 RCW~~)) Any member of a health profession listed under RCW 18.130.040 who, in good faith, makes a report, files charges, or presents evidence against another member of ((~~their~~)) a health profession based on the claimed ((~~incompetency or gross misconduct~~)) unprofessional conduct as provided in RCW 18.130.180 or inability to practice with reasonable skill and safety to consumers by reason of any physical or mental condition as provided in RCW 18.130.170 of such person before the ((~~medical quality assurance commission established under chapter 18.71 RCW, in a proceeding under chapter 18.32 RCW, or to the board of pharmacy under RCW 18.64.160~~)) agency, board, or commission responsible for disciplinary activities for the person's profession under chapter 18.130 RCW, shall be immune from civil action for damages arising out of such activities. A person prevailing upon the good faith defense provided for in this section is entitled to recover expenses and reasonable attorneys' fees incurred in establishing the defense.

Sec. 42. RCW 18.71.0193 and 1994 sp.s. c 9 s 327 are each amended to read as follows:

(1) A ((~~licensed health care professional~~)) physician licensed under this chapter shall report to the commission when he or she has personal knowledge that a practicing physician has either committed an act or acts which may constitute statutorily defined unprofessional conduct or that a practicing physician may be unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material, or as a result of any mental or physical conditions.

(2) Reporting under this section is not required by:

(a) An appropriately appointed peer review committee member of a licensed hospital or by an appropriately designated professional review committee member of a county or state medical society during the investigative phase of their respective operations if these investigations are completed in a timely manner; or

(b) A treating licensed health care professional of a physician currently involved in a treatment program as long as the physician

patient actively participates in the treatment program and the physician patient's impairment does not constitute a clear and present danger to the public health, safety, or welfare.

(3) The commission may impose disciplinary sanctions, including license suspension or revocation, on any ((~~health care professional subject to the jurisdiction of the commission~~)) physician licensed under this chapter who has failed to comply with this section.

(4) Every physician licensed under this chapter who reports to the commission as required under subsection (1) of this section in good faith is immune from civil liability for damages arising out of the report, whether direct or derivative. A person prevailing upon the defense provided for in this section is entitled to recover expenses and reasonable attorneys' fees incurred in establishing the defense.

Sec. 43. RCW 18.130.010 and 1994 sp.s. c 9 s 601 are each amended to read as follows:

It is the intent of the legislature to strengthen and consolidate disciplinary and licensure procedures for the licensed health and health-related professions and businesses by providing a uniform disciplinary act with standardized procedures for the licensure of health care professionals and the enforcement of laws the purpose of which is to ((~~assure the public of the adequacy of professional competence and conduct in the healing arts~~)) reduce unprofessional conduct and unsafe practices in health care, protect the public health, safety, and welfare, and promote patient safety.

It is also the intent of the legislature that all health and health-related professions newly credentialed by the state come under the Uniform Disciplinary Act.

Further, the legislature declares that the addition of public members on all health care commissions and boards can give both the state and the public, which it has a paramount statutory responsibility to protect, assurances of accountability and confidence in the various practices of health care.

Sec. 44. RCW 18.130.180 and 1995 c 336 s 9 are each amended to read as follows:

The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising which is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

(5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction. Full faith and credit will be extended to the action by the competent authority, even if procedures or standards of proof vary in the other jurisdiction;

(6) The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances

or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers or documents;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or

(d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

(10) Aiding or abetting an unlicensed person to practice when a license is required;

(11) Violations of rules established by any health agency;

(12) Practice beyond the scope of practice as defined by law or rule;

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

(14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;

(15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty

or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(18) The procuring, or aiding or abetting in procuring, a criminal abortion;

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;

(20) The willful betrayal of a practitioner-patient privilege as recognized by law;

(21) Violation of chapter 19.68 RCW;

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

(23) Current misuse of:

(a) Alcohol;

(b) Controlled substances; or

(c) Legend drugs;

(24) Abuse of a client or patient or sexual contact with a client or patient;

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

Sec. 45. RCW 18.130.900 and 1986 c 259 s 14 are each amended to read as follows:

(1) This chapter shall be known and cited as the uniform disciplinary act.

(2) This chapter applies to any conduct, acts, or conditions occurring on or after June 11, 1986.

(3) This chapter does not apply to or govern the construction of and disciplinary action for any conduct, acts, or conditions occurring prior to June 11, 1986. Such conduct, acts, or conditions must be construed and disciplinary action taken according to the provisions of law existing at the time of the occurrence in the same manner as if this chapter had not been enacted.

(4) The amendments to chapter 18.130 RCW in sections 43 and 44 of this act are clarifying amendments and should not be construed as a change in the construction and application of chapter 18.130 RCW.

NEW SECTION. **Sec. 46.** The uniform disciplinary act provides a uniform process for addressing acts of unprofessional conduct affecting fifty-seven health professions regulated by the state. The disciplinary authorities include the secretary of health and sixteen boards and commissions charged with protecting the health and safety of patients from unprofessional conduct. It is recognized nationally as a model law and has worked well over time to provide uniformity and efficiency to the disciplinary process.

The legislature finds that it is necessary to further streamline the disciplinary process and ensure more equitable case dispositions among health care providers. An efficient division of responsibilities between the secretary of health with authority over most preliminary complaint investigations and charging decisions allows the health professionals sitting on the boards and commissions to retain the final authority on issuing findings and sanctions. These measures will ensure that investigations and charging decisions are free of any potential conflicts of interest and that sanctions are uniform across professional lines.

The legislature further finds that sections 47 through 54 of this act are not intended to change or modify, in any way, the relationship as it exists on the effective date of this section between boards and commissions and contractors providing services to impaired providers.

Sec. 47. RCW 18.130.050 and 1995 c 336 s 4 are each amended to read as follows:

The disciplining authority has the following authority:

(1) To adopt, amend, and rescind such rules as are deemed necessary to carry out this chapter;

(2) To ((~~investigate all~~)) provide consultation and assistance with investigations of complaints or reports of unprofessional conduct as defined in this chapter ((~~and~~)) as requested by the secretary. If the secretary determines that the complaint involves standards of practice or that clinical expertise is necessary, the secretary shall assure that the board or commission is actively involved in the investigation;

(3) To hold hearings as provided in this chapter;

((~~(3)~~)) (4) To issue subpoenas and administer oaths in connection with any investigation, hearing, or proceeding held under this chapter;

((~~(4)~~)) (5) To take or cause depositions to be taken and use other discovery procedures as needed in any investigation, hearing, or proceeding held under this chapter;

((~~(5)~~)) (6) To compel attendance of witnesses at hearings;

((~~(6)~~)) (7) In the course of ((~~investigating~~)) consulting and assisting with the investigation of a complaint or report of unprofessional conduct, to conduct practice reviews as requested by the secretary;

((~~(7) To take emergency action ordering summary suspension of a license, or restriction or limitation of the licensee's practice pending proceedings by the disciplining authority;~~))

(8) To use a presiding officer as authorized in RCW 18.130.095(3) or the office of administrative hearings as authorized in chapter 34.12 RCW to conduct hearings. The disciplining authority shall make the final decision regarding disposition of the license unless the disciplining authority elects to delegate in writing the final decision to the presiding officer;

(9) To use individual members of the boards to ((~~direct~~)) provide consultation and assistance with investigations as requested by the secretary. However, the member of the board shall not subsequently participate in the hearing of the case;

(10) To enter into contracts for professional services determined to be necessary for adequate enforcement of this chapter;

(11) To contract with licensees or other persons or organizations to provide services necessary for the monitoring and supervision of licensees who are placed on probation, whose professional activities are restricted, or who are for any authorized purpose subject to monitoring by the disciplining authority;

(12) To adopt standards of professional conduct or practice;

(13) To grant or deny license applications, and in the event of a finding of unprofessional conduct by an applicant or license holder, to impose any sanction against a license applicant or license holder provided by this chapter;

(14) To designate individuals authorized to sign subpoenas and statements of charges;

(15) To establish panels consisting of three or more members of the board to perform any duty or authority within the board's jurisdiction under this chapter;

(16) To review and audit the records of licensed health facilities' or services' quality assurance committee decisions in which a licensee's practice privilege or employment is terminated or restricted. Each health facility or service shall produce and make accessible to the disciplining authority the appropriate records and otherwise facilitate the review and audit. Information so gained shall not be subject to discovery or introduction into evidence in any civil action pursuant to RCW 70.41.200(3).

Sec. 48. RCW 18.130.060 and 2001 c 101 s 1 are each amended to read as follows:

In addition to the authority specified in RCW 18.130.050, the secretary has the following additional authority:

(1) To employ such investigative, administrative, and clerical staff as necessary for the enforcement of this chapter;

(2) Upon the request of a board, to appoint pro tem members to participate as members of a panel of the board in connection with proceedings specifically identified in the request. Individuals so appointed must meet the same minimum qualifications as regular members of the board. Pro tem members appointed for matters under this chapter are appointed for a term of no more than one year. No pro tem member may serve more than four one-year terms. While serving as board

members pro tem, persons so appointed have all the powers, duties, and immunities, and are entitled to the emoluments, including travel expenses in accordance with RCW 43.03.050 and 43.03.060, of regular members of the board. The chairperson of a panel shall be a regular member of the board appointed by the board chairperson. Panels have authority to act as directed by the board with respect to all matters ((~~concerning the review, investigation, and adjudication of all complaints, allegations, charges, and matters~~)) subject to the jurisdiction of the board. The authority to act through panels does not restrict the authority of the board to act as a single body at any phase of proceedings within the board's jurisdiction. Board panels may ((~~make interim orders and~~)) issue final orders and decisions with respect to matters and cases delegated to the panel by the board. Final decisions may be appealed as provided in chapter 34.05 RCW, the Administrative Procedure Act;

(3) To establish fees to be paid for witnesses, expert witnesses, and consultants used in any investigation and to establish fees to witnesses in any agency adjudicative proceeding as authorized by RCW 34.05.446;

(4) To conduct investigations and practice reviews ((~~at the direction of the disciplining authority~~)) and to issue subpoenas, administer oaths, and take depositions in the course of conducting those investigations and practice reviews ((~~at the direction of the disciplining authority~~)). The secretary may request the consultation and assistance of the appropriate disciplining authority, and where standards of practice or clinical expertise is necessary, the secretary shall assure that the board or commission is actively involved in the investigation;

(5) To review results of investigations conducted under this chapter and determine the appropriate disposition, which may include closure, notice of correction, stipulations permitted by RCW 18.130.172, or issuance of a statement of charges;

(6) To take emergency action ordering summary suspension of a license, or restriction or limitation of the license holder's practice pending proceedings by the disciplining authority;

(7) To have the health professions regulatory program establish a system to recruit potential public members, to review the

qualifications of such potential members, and to provide orientation to those public members appointed pursuant to law by the governor or the secretary to the boards and commissions specified in RCW 18.130.040(2)(b), and to the advisory committees and ((~~councils~~)) for professions specified in RCW 18.130.040(2)(a).

Sec. 49. RCW 18.130.080 and 1998 c 132 s 9 are each amended to read as follows:

A person, including but not limited to consumers, ((~~licensees~~)) license holders, corporations, organizations, health care facilities, impaired practitioner programs, or voluntary substance abuse monitoring programs approved by disciplining authorities, and state and local governmental agencies, may submit a written complaint to the ((~~disciplining authority~~)) secretary charging a license holder or applicant with unprofessional conduct and specifying the grounds therefor or to report information to the ((~~disciplining authority~~)) secretary, or voluntary substance abuse monitoring program, or an impaired practitioner program approved by the disciplining authority, which indicates that the license holder may not be able to practice his or her profession with reasonable skill and safety to consumers as a result of a mental or physical condition. If the ((~~disciplining authority~~)) secretary determines that the complaint merits investigation, or if the ((~~disciplining authority~~)) secretary has reason to believe, without a formal complaint, that a license holder or applicant may have engaged in unprofessional conduct, the ((~~disciplining authority~~)) secretary shall investigate to determine whether there has been unprofessional conduct. A person who files a complaint or reports information under this section in good faith is immune from suit in any civil action related to the filing or contents of the complaint.

Sec. 50. RCW 18.130.090 and 1993 c 367 s 1 are each amended to read as follows:

(1) If the ((~~disciplining authority~~)) secretary determines, upon investigation, that there is reason to believe a violation of RCW 18.130.180 has occurred, a statement of charge or charges ((~~shall~~)) may be prepared and served upon the license holder or applicant at the

earliest practical time. The statement of charge or charges shall be accompanied by a notice that the license holder or applicant may request ((~~a hearing~~)) an adjudicative proceeding to contest the charge or charges.

(a) The license holder or applicant must file a request for ((~~hearing~~)) an adjudicative proceeding with the disciplining authority within twenty days after being served the statement of charges. Nothing in this section precludes the license holder and the disciplinary authority from engaging in settlement negotiations and resolving the matter through a settlement. If the twenty-day limit results in a hardship upon the license holder or applicant, he or she may request for good cause an extension not to exceed sixty additional days. If the disciplining authority finds that there is good cause, it shall grant the extension.

(b) The failure to request ((~~a hearing~~)) an adjudicative proceeding constitutes a default((~~, whereupon~~)). The disciplining authority may then enter a decision on the basis of the facts available to it.

(2) As an alternative to filing a statement of charge or charges, the secretary may issue to a license holder or applicant a written notice of action identifying the allegations and proposed sanction, except revocation, authorized under RCW 18.130.160. The notice shall state the reasons for the action. The notice shall be sent to the license holder or applicant by certified mail, with return receipt requested.

(a) The applicant or license holder has the right to an adjudicative proceeding. If an adjudicative proceeding is requested, the action will be of no effect, other than to identify the allegations and proposed sanctions. The license holder or applicant must file a request for an adjudicative proceeding with the disciplining authority within thirty days after being served the action. If the thirty-day limit results in a hardship upon the license holder or applicant, he or she may request for good cause an extension not to exceed sixty additional days. If the disciplining authority finds that there is good cause, it shall grant the extension.

(b) In the event no request for an adjudicative proceeding is filed within the time allowed by (a) of this subsection and the department

has received the return receipt from the certified mailing, the action becomes effective.

(c) In the event that the license holder can show good cause for failure to receive and reply to the written notice of action and proposed sanction, the license holder may petition for reconsideration of the disciplinary action and imposed sanction and may request an adjudicative proceeding up to one year following the issuance of the initial written notice of charge and proposed sanction.

(3) If ((~~a hearing~~)) an adjudicative proceeding is requested, the time of the ((~~hearing~~)) adjudicative proceeding shall be fixed by the disciplining authority as soon as convenient, but the ((~~hearing~~)) adjudicative proceeding shall not be held earlier than thirty days after service of the charges or notice of action upon the license holder or applicant.

Sec. 51. RCW 18.130.160 and 2001 c 195 s 1 are each amended to read as follows:

Upon a finding, after hearing, that a license holder or applicant has committed unprofessional conduct or is unable to practice with reasonable skill and safety due to a physical or mental condition, the disciplining authority may issue an order providing for one or any combination of the following:

(1) Revocation of the license;

(2) Suspension of the license for a fixed or indefinite term;

(3) Restriction or limitation of the practice;

(4) Requiring the satisfactory completion of a specific program of remedial education or treatment;

(5) The monitoring of the practice by a supervisor approved by the disciplining authority;

(6) Censure or reprimand;

(7) Compliance with conditions of probation for a designated period of time;

(8) Payment of a fine for each violation of this chapter, not to exceed five thousand dollars per violation. Funds received shall be placed in the health professions account;

(9) Denial of the license request;

(10) Corrective action;

(11) Refund of fees billed to and collected from the consumer;

(12) A surrender of the practitioner's license in lieu of other sanctions, which must be reported to the federal data bank.

Except as otherwise provided in section 54 of this act, any of the actions under this section may be totally or partly stayed by the disciplining authority. In determining what action is appropriate, the disciplining authority must first consider what sanctions are necessary to protect or compensate the public. Only after such provisions have been made may the disciplining authority consider and include in the order requirements designed to rehabilitate the license holder or applicant. All costs associated with compliance with orders issued under this section are the obligation of the license holder or applicant.

The licensee or applicant may enter into a stipulated disposition of charges that includes one or more of the sanctions of this section, but only after a statement of charges has been issued and the licensee has been afforded the opportunity for a hearing and has elected on the record to forego such a hearing. The stipulation shall either contain one or more specific findings of unprofessional conduct or inability to practice, or a statement by the licensee acknowledging that evidence is sufficient to justify one or more specified findings of unprofessional conduct or inability to practice. The stipulation entered into pursuant to this subsection shall be considered formal disciplinary action for all purposes.

Sec. 52. RCW 18.130.170 and 1995 c 336 s 8 are each amended to read as follows:

(1) If the ((~~disciplining authority~~)) secretary believes a license holder or applicant may be unable to practice with reasonable skill and safety to consumers by reason of any mental or physical condition, a statement of charges in the name of the ((~~disciplining authority~~)) secretary shall be served on the license holder or applicant and notice shall also be issued providing an opportunity for a hearing. The hearing shall be limited to the sole issue of the capacity of the license holder or applicant to practice with reasonable skill and safety. If the disciplining authority determines that the license holder or applicant is unable to practice with reasonable skill and

safety for one of the reasons stated in this subsection, the disciplining authority shall impose such sanctions under RCW 18.130.160 as is deemed necessary to protect the public.

(2)(a) In investigating or adjudicating a complaint or report that a license holder or applicant may be unable to practice with reasonable skill or safety by reason of any mental or physical condition, the ((~~disciplining authority~~)) secretary may require a license holder or applicant to submit to a mental or physical examination by one or more licensed or certified health professionals designated by the ((~~disciplining authority~~)) secretary. The license holder or applicant shall be provided written notice of the ((~~disciplining authority's~~)) secretary's intent to order a mental or physical examination, which notice shall include: (i) A statement of the specific conduct, event, or circumstances justifying an examination; (ii) a summary of the evidence supporting the ((~~disciplining authority's~~)) secretary's concern that the license holder or applicant may be unable to practice with reasonable skill and safety by reason of a mental or physical condition, and the grounds for believing such evidence to be credible and reliable; (iii) a statement of the nature, purpose, scope, and content of the intended examination; (iv) a statement that the license holder or applicant has the right to respond in writing within twenty days to challenge the ((~~disciplining authority's~~)) secretary's grounds for ordering an examination or to challenge the manner or form of the examination; and (v) a statement that if the license holder or applicant timely responds to the notice of intent, then the license holder or applicant will not be required to submit to the examination while the response is under consideration.

(b) Upon submission of a timely response to the notice of intent to order a mental or physical examination, the license holder or applicant shall have an opportunity to respond to or refute such an order by submission of evidence or written argument or both. The evidence and written argument supporting and opposing the mental or physical examination shall be reviewed by either a panel of the disciplining authority members who have not been involved with the allegations against the license holder or applicant or a neutral decision maker approved by the disciplining authority. The reviewing panel of the disciplining authority or the approved neutral decision maker may, in

its discretion, ask for oral argument from the parties. The reviewing panel of the disciplining authority or the approved neutral decision maker shall prepare a written decision as to whether: There is reasonable cause to believe that the license holder or applicant may be unable to practice with reasonable skill and safety by reason of a mental or physical condition, or the manner or form of the mental or physical examination is appropriate, or both.

(c) Upon receipt by the ((~~disciplining authority~~)) secretary of the written decision, or upon the failure of the license holder or applicant to timely respond to the notice of intent, the ((~~disciplining authority~~)) secretary may issue an order requiring the license holder or applicant to undergo a mental or physical examination. All such mental or physical examinations shall be narrowly tailored to address only the alleged mental or physical condition and the ability of the license holder or applicant to practice with reasonable skill and safety. An order of the ((~~disciplining authority~~)) secretary requiring the license holder or applicant to undergo a mental or physical examination is not a final order for purposes of appeal. The cost of the examinations ordered by the ((~~disciplining authority~~)) secretary shall be paid out of the health professions account. In addition to any examinations ordered by the ((~~disciplining authority~~)) secretary, the licensee may submit physical or mental examination reports from licensed or certified health professionals of the license holder's or applicant's choosing and expense.

(d) If the disciplining authority finds that a license holder or applicant has failed to submit to a properly ordered mental or physical examination, then the disciplining authority may order appropriate action or discipline under RCW 18.130.180(9), unless the failure was due to circumstances beyond the person's control. However, no such action or discipline may be imposed unless the license holder or applicant has had the notice and opportunity to challenge the ((~~disciplining authority's~~)) secretary's grounds for ordering the examination, to challenge the manner and form, to assert any other defenses, and to have such challenges or defenses considered by either a panel of the disciplining authority members who have not been involved with the allegations against the license holder or applicant or a neutral decision maker approved by the disciplining authority, as

previously set forth in this section. Further, the action or discipline ordered by the disciplining authority shall not be more severe than a suspension of the license, certification, registration or application until such time as the license holder or applicant complies with the properly ordered mental or physical examination.

(e) Nothing in this section shall restrict the power of ((~~a disciplining authority~~)) the secretary to act in an emergency under RCW 34.05.422(4), 34.05.479, and ((~~18.130.050(7)~~)) 18.130.060(6).

(f) A determination by a court of competent jurisdiction that a license holder or applicant is mentally incompetent or mentally ill is presumptive evidence of the license holder's or applicant's inability to practice with reasonable skill and safety. An individual affected under this section shall at reasonable intervals be afforded an opportunity, at his or her expense, to demonstrate that the individual can resume competent practice with reasonable skill and safety to the consumer.

(3) For the purpose of subsection (2) of this section, an applicant or license holder governed by this chapter, by making application, practicing, or filing a license renewal, is deemed to have given consent to submit to a mental, physical, or psychological examination when directed in writing by the ((~~disciplining authority~~)) secretary and further to have waived all objections to the admissibility or use of the examining health professional's testimony or examination reports by the ((~~disciplining authority~~)) secretary on the ground that the testimony or reports constitute privileged communications.

Sec. 53. RCW 18.130.172 and 2000 c 171 s 29 are each amended to read as follows:

(1) Except for those acts of unprofessional conduct specified in section 54 of this act, prior to serving a statement of charges under RCW 18.130.090 or 18.130.170, the ((~~disciplinary authority~~)) secretary may furnish a statement of allegations to the licensee or applicant along with a detailed summary of the evidence relied upon to establish the allegations and a proposed stipulation for informal resolution of the allegations. These documents shall be exempt from public disclosure until such time as the allegations are resolved either by stipulation or otherwise.

(2) The ((~~disciplinary authority~~)) secretary and the applicant or licensee may stipulate that the allegations may be disposed of informally in accordance with this subsection. The stipulation shall contain a statement of the facts leading to the filing of the complaint; the act or acts of unprofessional conduct alleged to have been committed or the alleged basis for determining that the applicant or licensee is unable to practice with reasonable skill and safety; a statement that the stipulation is not to be construed as a finding of either unprofessional conduct or inability to practice; an acknowledgement that a finding of unprofessional conduct or inability to practice, if proven, constitutes grounds for discipline under this chapter; and an agreement on the part of the licensee or applicant that the sanctions set forth in RCW 18.130.160, except RCW 18.130.160 (1), (2), (6), and (8), may be imposed as part of the stipulation, except that no fine may be imposed but the licensee or applicant may agree to reimburse the ((~~disciplinary authority~~)) secretary the costs of investigation and processing the complaint up to an amount not exceeding one thousand dollars per allegation; and an agreement on the part of the ((~~disciplinary authority~~)) secretary to forego further disciplinary proceedings concerning the allegations. A stipulation entered into pursuant to this subsection shall not be considered formal disciplinary action.

(3) If the licensee or applicant declines to agree to disposition of the charges by means of a stipulation pursuant to subsection (2) of this section, the ((~~disciplinary authority~~)) secretary may proceed to formal disciplinary action pursuant to RCW 18.130.090 or 18.130.170.

(4) Upon execution of a stipulation under subsection (2) of this section by both the licensee or applicant and the ((~~disciplinary authority~~)) secretary, the complaint is deemed disposed of and shall become subject to public disclosure on the same basis and to the same extent as other records of the ((~~disciplinary authority~~)) secretary. Should the licensee or applicant fail to pay any agreed reimbursement within thirty days of the date specified in the stipulation for payment, the ((~~disciplinary authority~~)) secretary may seek collection of the amount agreed to be paid in the same manner as enforcement of a fine under RCW 18.130.165.

NEW SECTION. **Sec. 54.** A new section is added to chapter 18.130 RCW to read as follows:

(1) The disciplining authority shall revoke the license of a license holder who is found to have committed three acts of unprofessional conduct from the following list in any combination within a ten-year period:

(a) Any act defined in RCW 18.130.180(4) that causes or substantially contributes to the death of or severe injury to a patient or creates a significant risk of harm to the public;

(b) Any act defined in RCW 18.130.180(6);

(c) Any act defined in RCW 18.130.180(7) that causes or substantially contributes to the death of or severe injury to a patient or creates a significant risk of harm to the public;

(d) Any act defined in RCW 18.130.180(17);

(e) Any act defined in RCW 18.130.180(23) that causes or substantially contributes to the death of or severe injury to a patient or creates a significant risk of harm to the public;

(f) Any act of abuse to a client or patient as defined in RCW 18.130.180(24); and

(g) Any sexual contact with a client or patient as defined in RCW 18.130.180(24).

(2) For purposes of determining whether a license holder is found to have committed three acts of unprofessional conduct for purposes of this section:

(a) Under subsection (1)(g) of this section, one or more acts with one patient or client that are charged as part of one statement of charges shall be considered one act of unprofessional conduct; and

(b) Under subsection (1)(a) through (f) of this section, each incident of unprofessional conduct shall be considered one act of unprofessional conduct.

(3) A finding of mitigating circumstance for an act of unprofessional conduct may be issued and, except for (a) of this subsection, applied one time for any license holder or applicant for a license, and if so, that finding of unprofessional conduct shall not count as one of the three that triggers a license revocation for purposes of this section. A finding of mitigating circumstances under (a) of this subsection may be issued and applied as many times as the

license holder meets the criteria for such a finding and shall not count as one of the three findings that triggers the revocation of a license for the purposes of this section. Except for (a) of this subsection, after a finding of mitigating circumstances is issued and applied, no subsequent findings under this section may consider any mitigating circumstances. The following mitigating circumstances may be considered:

(a) For subsection (1)(a) of this section, the act involved a high-risk procedure, there was no lower-risk alternative to that procedure, the patient was informed of the risks of the procedure and consented to it anyway, and prior to the institution of disciplinary actions the license holder took appropriate remedial measures;

(b) There is a strong potential for rehabilitation of the license holder; or

(c) There is a strong potential for remedial education and training to prevent future harm to the public.

(4) Nothing in this section limits the authority of the disciplining authority to revoke a license or take other disciplinary action when the license holder has committed only one or two acts of unprofessional conduct instead of three.

Sec. 55. RCW 18.130.190 and 2003 c 53 s 141 are each amended to read as follows:

(1) The secretary shall investigate complaints concerning practice by unlicensed persons of a profession or business for which a license is required by the chapters specified in RCW 18.130.040. In the investigation of the complaints, the secretary shall have the same authority as provided the secretary under RCW 18.130.050 and 18.130.060.

(2) The secretary may issue a notice of intention to issue a cease and desist order to any person whom the secretary has reason to believe is engaged in the unlicensed practice of a profession or business for which a license is required by the chapters specified in RCW 18.130.040. The person to whom such notice is issued may request an adjudicative proceeding to contest the charges. The request for hearing must be filed within twenty days after service of the notice of intention to issue a cease and desist order. The failure to request a

hearing constitutes a default, whereupon the secretary may enter a permanent cease and desist order, which may include a civil fine. All proceedings shall be conducted in accordance with chapter 34.05 RCW.

(3) If the secretary makes a final determination that a person has engaged or is engaging in unlicensed practice, the secretary may issue a cease and desist order. In addition, the secretary may impose a civil fine in an amount not exceeding one thousand dollars for each day upon which the person engaged in unlicensed practice of a business or profession for which a license is required by one or more of the chapters specified in RCW 18.130.040. The proceeds of such fines shall be deposited to the health professions account.

(4) If the secretary makes a written finding of fact that the public interest will be irreparably harmed by delay in issuing an order, the secretary may issue a temporary cease and desist order. The person receiving a temporary cease and desist order shall be provided an opportunity for a prompt hearing. The temporary cease and desist order shall remain in effect until further order of the secretary. The failure to request a prompt or regularly scheduled hearing constitutes a default, whereupon the secretary may enter a permanent cease and desist order, which may include a civil fine.

(5) Neither the issuance of a cease and desist order nor payment of a civil fine shall relieve the person so practicing or operating a business without a license from criminal prosecution therefor, but the remedy of a cease and desist order or civil fine shall be in addition to any criminal liability. The cease and desist order is conclusive proof of unlicensed practice and may be enforced under RCW 7.21.060. This method of enforcement of the cease and desist order or civil fine may be used in addition to, or as an alternative to, any provisions for enforcement of agency orders set out in chapter 34.05 RCW.

(6) The attorney general, a county prosecuting attorney, the secretary, a board, or any person may in accordance with the laws of this state governing injunctions, maintain an action in the name of this state to enjoin any person practicing a profession or business for which a license is required by the chapters specified in RCW 18.130.040 without a license from engaging in such practice or operating such business until the required license is secured. However, the

injunction shall not relieve the person so practicing or operating a business without a license from criminal prosecution therefor, but the remedy by injunction shall be in addition to any criminal liability.

(7)(a) Unlicensed practice of a profession or operating a business for which a license is required by the chapters specified in RCW 18.130.040, unless otherwise exempted by law, constitutes a gross misdemeanor for a single violation.

(b) Each subsequent violation, whether alleged in the same or in subsequent prosecutions, is a class C felony punishable according to chapter 9A.20 RCW.

(8) All fees, fines, forfeitures, and penalties collected or assessed by a court because of a violation of this section shall be remitted to the health professions account.

PART V - MISCELLANEOUS

NEW SECTION. **Sec. 56.** Sections 14 and 15 of this act expire July 1, 2006.

NEW SECTION. **Sec. 57.** Sections 18 through 23 of this act constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 58.** Sections 31 through 38 of this act expire December 31, 2010.

NEW SECTION. **Sec. 59.** Section 33 of this act takes effect July 1, 2004.

NEW SECTION. **Sec. 60.** Section 55 of this act takes effect January 1, 2005.

NEW SECTION. **Sec. 61.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 62.** Part headings used in this act are not any part of the law."

Correct the title.

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